State of Hawai`i

Department of Human Services

Med-QUEST Division

Hawai`i Medicaid EHR Incentive Program

Provider Manual

April 2016

Document Approval and History

Version	Revision	Date	Comments
2.0	Original Document	03/21/2016	Reviewed and approved by MQD.

Table of Contents

1 Purpose

The Hawaii Medicaid EHR Incentive Program Provider Manual is a resource for healthcare professionals and hospitals who wish to learn more about the Medicaid EHR Incentive Program for Hawaii. This manual provides detailed information on the State of Hawaii's EHR policies, including provider eligibility and attestation criteria. Understanding and acknowledgement of reading the Hawaii Medicaid EHR Incentive Program Provider Manual is required to complete the Hawaii Registration & Attestation System and obtain EHR Incentive Payment.

This manual is organized by EHR Incentive Program eligibility requirements, patient volume methodology, program payment methodology, meaningful use quality measures and program registration requirements for both eligible professionals (EP) and eligible hospitals (EH).

The best way for a new user to orient themselves to the EHR Incentive Program requirements and processes is to read through each section of this manual in its entirety prior to starting the attestation process.

2 Background

The Centers for Medicare & Medicaid Services (CMS) has implemented, through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments to eligible professionals (EP) and eligible hospitals (EH), including critical access hospitals (CAHs), participating in Medicare and Medicaid programs who adopt, implement, upgrade, or meaningfully use certified Electronic Health Records (EHR) technology. Under ARRA, states are responsible for identifying professionals and hospitals that are eligible for these Medicaid EHR incentive payments, making payments, and monitoring use of the payments. The incentive payments are not a reimbursement, but are intended to encourage EPs and EHs to adopt and meaningfully use certified EHR technology.

Use of certified EHR systems is required to qualify for incentive payments. The Office of the National Coordinator for Health Information Technology (ONC) has issued rules defining certified EHR systems and has identified entities that may certify systems. More information about this process is available at www.healthit.gov.

CMS released a final rule in October 2015 with provisions that cover 2015 through 2017 (referred to as Modified Stage 2), as well as Stage 3 in 2018 and beyond. The final rule specifies criteria that EPs and EHs must meet in order to participate in the Medicare and Medicaid EHR Incentive Programs.

Goals for the national program include:

- Enhance care coordination and patient safety;
- Reduce paperwork and improve efficiencies;
- Facilitate electronic information sharing across providers, payers, and state lines; and
- Enable data sharing using state Health Information Exchange (HIE) and the Nationwide Health Information Network (NwHIN). Achieving these goals will improve health outcomes, facilitate access, simplify care, and reduce costs of health care nationwide.

Resources:

- 42 CFR Parts 412, 413, 422, 495 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule
- Hawaii Provider Outreach Page, http://hi.arraincentive.com
- Medicare and Medicaid EHR Incentive Program, www.cms.gov/EHRIncentivePrograms
- Office of the National Coordinator for Health Information Technology, www.HealthIT.gov
- Hawaii Health Information Exchange, https://www.hawaiihie.org

Glossary of Terms

Term/Acronym	Explanation/Expansion
AIU	Adopt, Implement, Upgrade (certified EHR Technology)
ARRA	American Recovery and Reinvestment Act of 2009
CAH	Critical Access Hospital
CCN	CMS Certification Number
CEHRT	Certified Electronic Health Record Technology
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CPOE	Computerized Physician Order Entry
CQM	Clinical Quality Measures
CY	Calendar Year
EH	Eligible Hospital
EHR	Electronic Health Record
EIN	Employer Identification Number
EP	Eligible Professional
FA	Xerox Medicaid Fiscal Agent Services
FFS	Fee-For-Service
FFY	Federal Fiscal Year
FQHC	Federally Qualified Health Center
FY	Fiscal Year
HI	State of Hawaii
HIE	Health Information Exchange
HIT	Health Information Technology
HPMMIS	Hawaii Prepaid Medical Management Information System
HPREC	Hawaii Pacific Regional Extension Center
MQD	Med-QUEST Division
MU	Meaningful Use
NwHIN	Nationwide Health Information Network
NLR	National Level Repository
NPI	National Provider Identifier
ONC	Office of National Coordinator for Health Information Technology
PCP	Primary Care Provider
POS	Place of Service
PQRI	Physician Quality Reporting Initiative
RHC	Rural Health Clinic
SLR	Xerox State Level Registry (SLR)
SSN	Social Security Number
TIN	Tax Identification Number- Either an SSN or EIN

3 How Do I Get Help?

If you have any questions or problems, please contact the Hawaii Medicaid Fiscal Agent Call Center. The Hawaii Medicaid Fiscal Agent Call Center is the central point-of-contact to aid providers in enrolling in the Medicaid EHR Incentive Program and providing education and outreach to all Hawaii Medicaid Providers.

Address: P.O. Box 1220, Honolulu, HI 96807-1220

Email Address: SLRHelpdesk@xerox.com

Telephone Number: (800) 235-4378, option 7

For policy questions, email: MQD_EHRIncentive@dhs.hawaii.gov

There are a number of resources available to assist providers with the Hawaii Medicaid EHR Incentive Program attestation process. These resources may be obtained at: http://hi.arraincentive.com/. For specific information on using the Hawaii Medicaid State Level Registry (SLR), which is the Med-QUEST Division's (MQD) web-based EHR Incentive Program attestation system, please refer to the Hawaii State Level Registry for Provider Incentive Payments User Manuals. The manuals for EPs, EHs, and Groups are located in the SLR in a "Help" link on the dashboard homepage.

4 Eligible Provider Types

Per the federal rule, EPs must begin participation in the program no later than calendar year (CY) 2016 and EHs must begin by federal fiscal year (FFY) 2016. The following Hawaii Medicaid providers and out-of-state providers who are enrolled in the Hawaii Medicaid Program are eligible to participate in the Hawaii Medicaid EHR Incentive Program.

Eligible Professionals

- Certified Nurse-Midwife
- Dentist
- Doctor of Medicine
- Doctor of Osteopathic Medicine
- Optometrist
- Pediatrician (MD or DO)
- Physician Assistants (PA) [1], who furnishes services in a Federally Qualified Health Center (FQHC) or a Rural Health Center (RHC) that is so-led by a PA.
- Registered Nurse Practitioner

[1] If the FQHC where the Physician Assistant (PA) is working is led by a PA, then the PA is considered an eligible professional under the Medicaid EHR Incentive Program. An FQHC is considered so-led by a PA when: (1) a PA is the primary provider in a clinic (for example, when there is a part-time physician and full-time PA, we would consider the PA as the primary provider); or (2) a PA is a clinical or medical director at a clinical site of practice.

Medical and Dental Residents are eligible to participate in the Medicaid EHR Incentive Program, as long as they meet the criteria of being a licensed professional with a Hawaii Medicaid ID, and can meet the eligibility requirements.

Eligible Hospitals

- Acute care hospitals, including critical access hospitals (CAH)
- Children's hospitals

Note: Providers and hospitals that are currently ineligible for the Hawaii Medicaid EHR Incentive Program include behavioral health (substance abuse and mental health) providers and facilities, and long-term care providers and facilities. Note that some provider types eligible for the Medi*care* program, such as chiropractors, are not eligible for the Medicaid EHR Incentive Program per federal regulations.

5 Enrollment Requirements

Requirements for an Eligible Professional

To qualify for an EHR incentive payment for each year the EP seeks the incentive payment, the EP must meet the following criteria:

- Meet one of the following patient volume criteria:
  - Have at least 30 percent patient volume attributable to those who are receiving Medicaid; or
  - Have at least 20 percent patient volume attributed to those who are receiving medical assistance under the Medicaid program, and be a pediatrician [1]; or
  - Practice predominantly in an FQHC or RHC and have at least 30 percent patient volume attributable to "Needy Individuals." [2]
- Have a valid contract with MQD [3];
- Have no sanctions and/or exclusions; and
- May not be a hospital-based provider [4] [hospital-based is defined as a physician who provides at least 90 percent or more of his/her services in a hospital inpatient (Place of Service 21) or emergency room (Place of Service 23) setting.

[1] For the purposes of this program, MQD defines a pediatrician as a practitioner who is board certified through the American Board of Pediatrics web site *or* through the American Osteopathic Board of Pediatrics.

[2] A "Needy Individual" is defined as individuals that meet one of the following:

- Received medical assistance from Medicaid or the Children's Health Insurance Program. (Or a Medicaid or CHIP demonstration project approved under section 1115 of the Act.)
- Were furnished uncompensated care by the provider.
- Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

[3] A valid contract means that the provider is currently enrolled with MQD to provide services. An individual EP may choose to receive the incentive him/herself or assign it to a Medicaid contracted clinic or group to which he/she is associated. The tax identification number (TIN) of the individual or entity receiving the incentive payment is required when registering with the Centers for Medicare and Medicaid EHR Incentive Program Registration and Attestation System. The TIN of the individual or entity receiving the incentive payment must match a TIN linked to the individual provider in the Hawaii Prepaid Medical Management Information System (HPMMIS). For entities that do not link providers to their HPMMIS enrollment, the provider must be in contractual arrangement with the group or clinic to which they assign their payment.

[4] Hospital-based providers are not eligible for the Medicaid EHR Incentive Program; however the statute is also capable of other permissible interpretations. EPs who can demonstrate that they have funded the acquisition, implementation, and maintenance of Certified EHR Technology (CEHRT), including supporting hardware and interfaces to meet MU without reimbursement from any EH or CAH are eligible for the EHR Incentive Program. The EP would include all encounters at all locations in their MU attestation, including those in the inpatient and emergency departments of the hospital, rather than just outpatient locations.

Requirements for an Eligible Hospital

To qualify for an EHR incentive payment for each year the EH seeks the incentive payment, the EH must meet the following criteria:

- An acute care hospital including Critical Access Hospitals (CAH)
    - Medicaid discharges of at least 10% for the Medicaid patient volume;
    - An average Length of Stay (LOS) of 25 days or less; and
    - A CCN that ends in 0001 – 0879 or 1300 – 1399.
- A children's hospital
    - Children's hospitals are automatically eligible to participate in the program, regardless of whether discharges and average length of stay meet the minimum criteria.

Qualifying Providers by Provider Type and Patient Volume

Provider Types	Patient Volume over 90-Days Period
Eligible Hospital	
Acute Care Hospital (includes CAH)	• 10% Medicaid
Children's Hospital	• No Medicaid volume requirement
Eligible Professional	
Certified Nurse-Midwife	• 30% Medicaid • For EPs practicing in an FQHC/RHC – 30% Other Needy Individuals
Dentist	
Doctor of Medicine	
Doctor of Osteopathic Medicine	
Optometrist	
Physician Assistants in FQHC/RHC so-led by a PA	
Registered Nurse Practitioners	
Pediatrician (MD or DO)	• 30% Medicaid • If Pediatrician patient volume = 20-29%, the provider may qualify for 2/3 of incentive payment

Out-of-State Providers

The Hawaii Medicaid EHR Incentive Program allows out-of-state providers to participate in this advantageous program. Out-of-state providers have the same eligibility requirements as in-state providers. Hawaii must be the only state they are requesting an incentive payment from during that participation year. For audit purposes, out-of-state providers must make available any and all records, claims data, and other data pertinent to an audit by either the MQD or CMS. Records must be maintained as applicable by law in the State of practice or Hawaii, whichever is deemed longer.

6 Patient Volume Methodology

A Medicaid provider must meet patient volume requirements annually for the Hawaii Medicaid EHR Incentive Program. For the purpose of determining eligibility, all patient encounters used to calculate Medicaid patient volume or Other Needy Individual patient volume must be calculated using a 90-day representative, continuous period within the preceding calendar year or within the preceding 12 month period from the date of the attestation; this is known as the Eligibility Reporting Period.

Eligible Professional Patient Encounter Calculation

For EPs who are not practicing predominantly in an FQHC or RHC, patient volume will be calculated based on patient panels or encounters for dual-eligible individuals (i.e. eligible for both Medicare and Medicaid).

For EPs practicing predominantly in an FQHC or RHC, the Medicaid patient volume may be calculated using the Other Needy Individual patient volume requirements. Practicing predominantly is defined as an EP practicing at a FQHC or a RHC clinical location, for over 50 percent of their total patient encounters in a six (6) month period in the previous calendar year or the twelve (12) month period preceding the attestation.

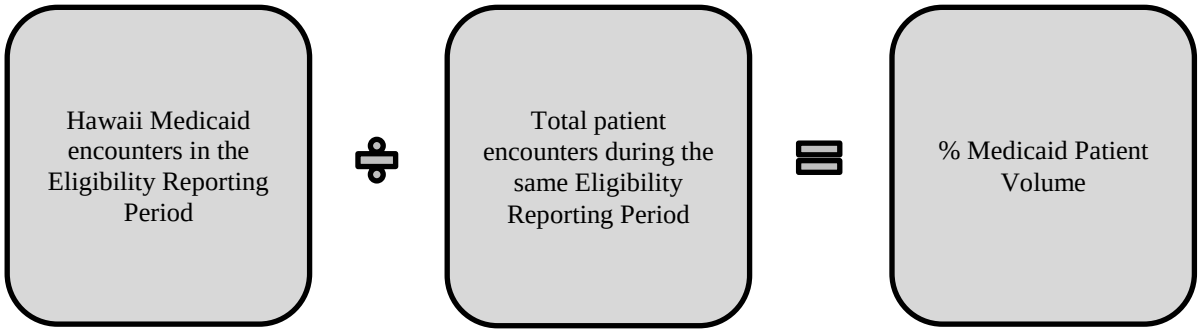
If an EP renders care to Medicaid patients at multiple locations, they are permitted to use data from all locations or limit them to one or more locations when calculating individual patient volume. However, at least one of the locations used must have certified EHR technology.

Eligible Professional Medicaid Encounter

For purposes of calculating the EP patient volume, a Medicaid encounter is defined as services rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability. This includes encounters for dual-eligible individuals (i.e. eligible for both Medicare and Medicaid), as well as zero-pay claims and encounters with patients in Title XXI-funded Medicaid expansions, but not separate CHIP programs. Total patient encounters are defined as all individuals for whom services were rendered on any one day.

To calculate Hawaii Medicaid patient volume, an EP must divide:

1. The total Hawaii Medicaid patient encounters in any representative, continuous 90-day period in the preceding calendar year or preceding 12 month period from the date of the attestation; by
2. The total patient encounters in the same 90-day period.



Eligible Professional Patient Panel Encounter

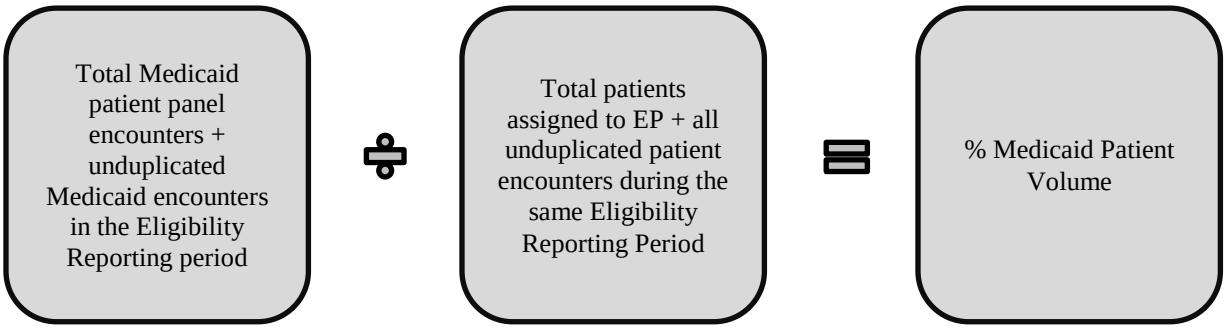
Patient panels are the alternate volume calculation available only to EPs who are primary care providers (PCP) and are treating Medicaid managed care patients, as well as any additional encounters outside of a care management arrangement (for example - Medicaid Fee-For-Service).

A Medicaid panel encounter is the total number of Medicaid patients assigned to an EP's panel in any Eligibility Reporting Period, when at least one Medicaid encounter took place with the Medicaid patient in the 24 months prior to the chosen Eligibility Reporting Period, plus all other Medicaid encounters in the same Eligibility Reporting Period. Note, while EPs may add in encounters with other, non-panel Medicaid patients to the numerator, these encounters must be patients who are not assigned to a panel and would be encounters that occurred during the representative 90-day period.

A total patient panel encounter is the total number of patients assigned to an EP's panel in any qualifying Eligibility Reporting Period, when at least one encounter took place with the patient in the 24 months prior to the chosen Eligibility Reporting Period. The numerator for patient volume is calculated as unduplicated Medicaid encounters plus Medicaid panel members.

To calculate Hawaii Medicaid patient volume using the panel method, an EP must divide:

1. Total Medicaid patients assigned to EP's panel + Unduplicated Medicaid Encounters; by
2. Total patients assigned to EP + All unduplicated patient encounters.



Eligible Professional Other Needy Individual Patient Encounter

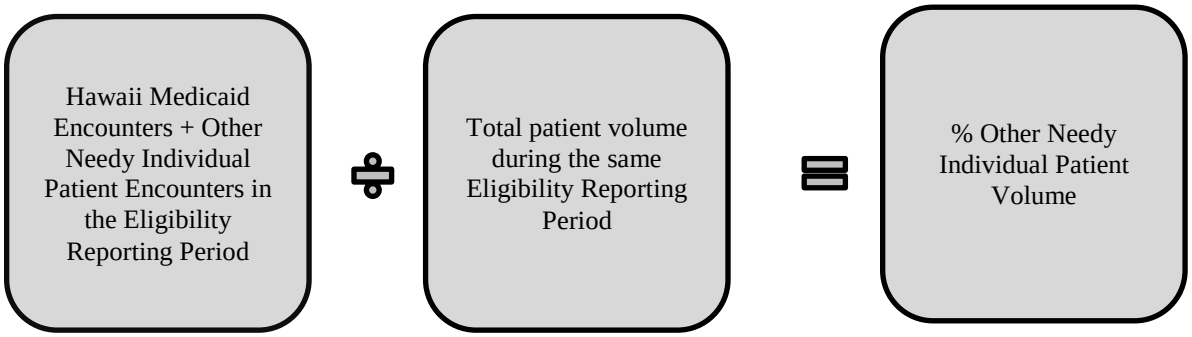
For purposes of calculating the patient volume for an EP practicing predominantly in an FQHC/RHC and completing the attestation in the SLR, EPs must be able to separate the Medicaid encounters from all Other Needy Individual Encounters, as they are recorded separately. To ensure that EPs do not double count the Medicaid encounters in the attestation, EPs should identify the following totals for entry as part of the attestation:

- Total Encounters
- Medicaid Encounters
- All Other Needy Individual encounters (Patients furnished services at no cost, and patient furnished services based on a sliding fee scale). EPs may calculate this number by subtracting the Medicaid encounters from the total Needy Individual encounters that the EP has identified.

Total patient encounters include all individuals in which services were rendered on any one day.

To calculate Other Needy Individual patient volume, an EP must divide:

1. Hawaii Medicaid Encounters + Other Needy Individual Patient Encounters in any representative, continuous 90-day period in the preceding calendar year or preceding 12 month period from the date of the attestation; by
2. The total patient encounters in the same 90-day period.



Eligible Professional Other Needy Individual Patient Panel Encounter

Other Needy Individual patient panel encounter is defined as the total Other Needy Individual patients assigned to an EP's panel in any Eligibility Reporting Period, when at least one Other Needy Individual encounter took place with the patient in the 24 months prior to the chosen Eligibility Reporting Period, plus unduplicated Other Needy Individual encounters in the same Eligibility Reporting Period.

A total patient panel encounter is defined as the total number of patients assigned to an EP's panel in any qualifying Eligibility Reporting Period, when at least one encounter took place with the patient in the 24 months prior to the chosen Eligibility Reporting Period, plus unduplicated patient encounters in the same Eligibility Reporting Period.

To calculate Hawaii patient volume using the Other Needy Individual patient panel method, an EP must divide:

1. Total Medicaid Panel Members Assigned + Total Medicaid Encounters + Other Needy Individual Patient Encounters; by
2. Total Panel Members Assigned + Total All Payer Encounters.

Group Practice Patient Encounter Calculation

Clinics or group practices will be permitted to calculate Medicaid patient volume at the group practice/clinic level, but only in accordance with all of the following limitations:

- There is an auditable data source (i.e., De-identified Practice Management Report) to support the clinic's or group practice's patient volume determination;
- All EPs in the group practice or clinic must agree to use the same patient volume methodology for the payment year.
    - If one provider in the group/clinic chooses to use individual patient volumes rather than the group volumes, all other providers in the group must also use individual patient volumes.
    - If one provider in the group/clinic also has an individual practice outside the group, and chooses to use their individual practice volumes rather than the group volumes, all other providers in the group can still use group volumes to qualify.
    - EPs that practice in two or more groups must elect to use the volume from only one of the groups.
- The clinic or group practice uses the entire practice or clinic's entire patient volume and does not limit patient volume in any way; and
- If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EPs outside encounters.
- Group volumes must include ALL practitioners in the group, even if they are not eligible for the EHR Incentive Program, i.e. podiatrists, dieticians, etc. Group encounters are not limited to the volumes of the eligible EPs.

Note: EPs can only participate in either the Medicare or Medicaid incentive program in the same payment year. If an EP is part of a Medicare EHR Incentive Group, they will not be able to receive a Medicaid EHR incentive payment or be included as part of a batch report for a Medicaid EHR Incentive Group or vice versa.

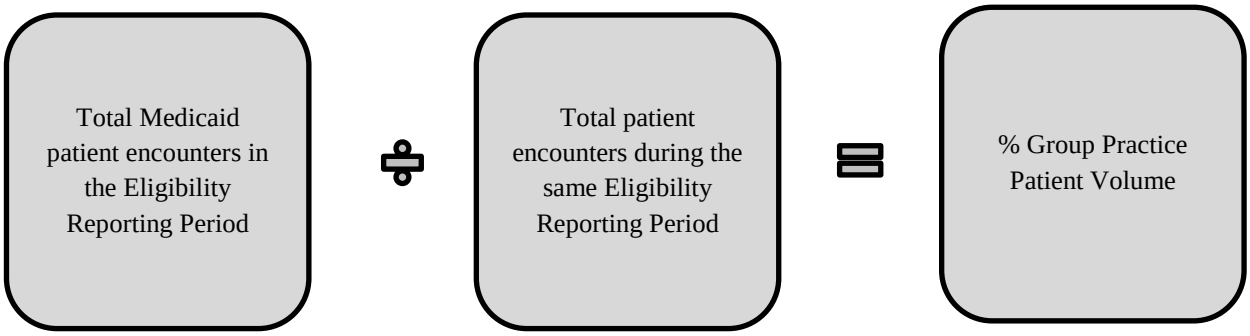
The group patient volume for a non-FQHC or RHC will be calculated based on Hawaii Medicaid patients. The group patient volume for a FQHC or RHC is calculated using the Other Needy Individual patient volume requirements, if the providers within the group practiced predominantly for over 50 percent of their total patient encounters in a six (6) month period, in the FQHC or RHC in the previous calendar year or the twelve (12) month period preceding the attestation.

Medicaid encounters are to include services rendered on any one day to a Medicaid patient, regardless of payment liability. This includes zero-pay claims and encounters with patients in Title XXI-funded Medicaid expansions, but not separate CHIP programs.

Group Medicaid Encounters

To calculate the group practice patient volume, a group must divide:

1. The total Hawaii Medicaid patient encounters in any representative, continuous 90-day period in the preceding calendar year or preceding 12 month period from the date of the attestation; by
2. The total patient encounters in the same 90-day period.

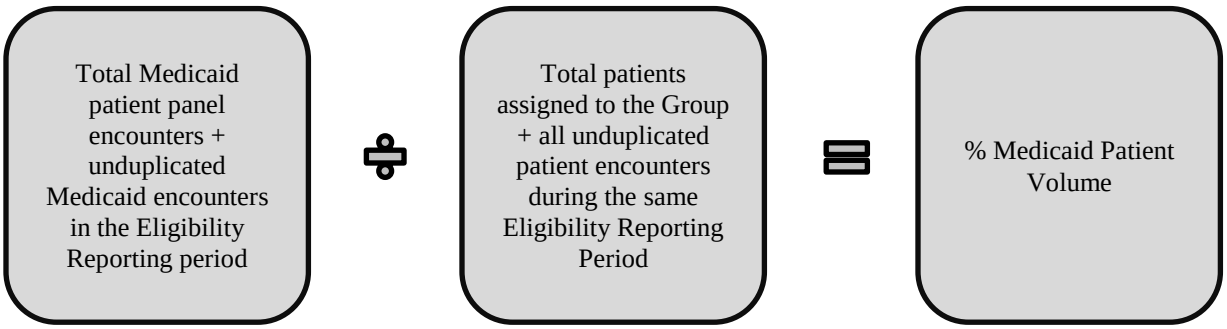


Group Patient Panel Encounter

In choosing a method for calculating patient volume (encounter or panel method), groups must first calculate patient volume for the group using the encounter method. If the group meets the 30 percent threshold (or 20 percent for pediatricians or pediatric dentists), the panel method is not needed. The panel method is most helpful for those who are not eligible to reach the volume threshold within the encounter method.

To calculate Hawaii Medicaid patient volume using the panel method, a Group must divide:

1. Total Medicaid patients assigned to Group's panel + Unduplicated Medicaid Encounters; by
2. Total patients assigned to the Group + All unduplicated patient encounters.

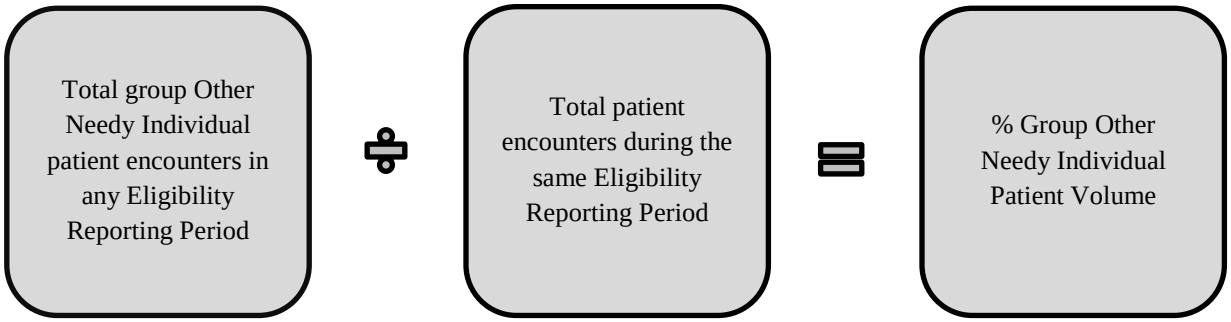


Group Other Needy Individual Encounters

In order for providers to use the group Other Needy Individual patient volume, all providers within the group must have practiced predominantly in the FQHC or RHC for over 50% of their encounters in a six (6) month period in the previous calendar year or the twelve (12) month period preceding the attestation.

To calculate the group Other Needy Individual patient volume, a group must divide:

1. The total group other Needy Individual patient encounters in any representative, continuous 90-day period in the preceding calendar year or preceding 12 month period from the date of the attestation; by
2. The total patient encounters in the same 90-day period.



Eligible Hospital Patient Encounter Calculation

Eligible Hospitals must determine eligibility for each year of participation in the Hawaii Medicaid EHR Incentive Program by calculating Medicaid patient volume. For purposes of calculating EH patient volume, a Medicaid encounter is defined as services rendered to an individual (1) per inpatient discharge, or (2) on any one day in the emergency room, regardless of payment liability. This includes encounters for dual-eligible individuals, as well as zero-pay claims and encounters with patients in Title XXI-funded Medicaid expansions, but not separate CHIP programs. Note, for dual-eligible individual encounters, if the EH is counting the patient for purposes of the Medicare EHR incentive program, they cannot also count the patient for the Medicaid EHR Incentive Program. Total patient encounters include all unique patients in which services were rendered on any one day, regardless of payer.

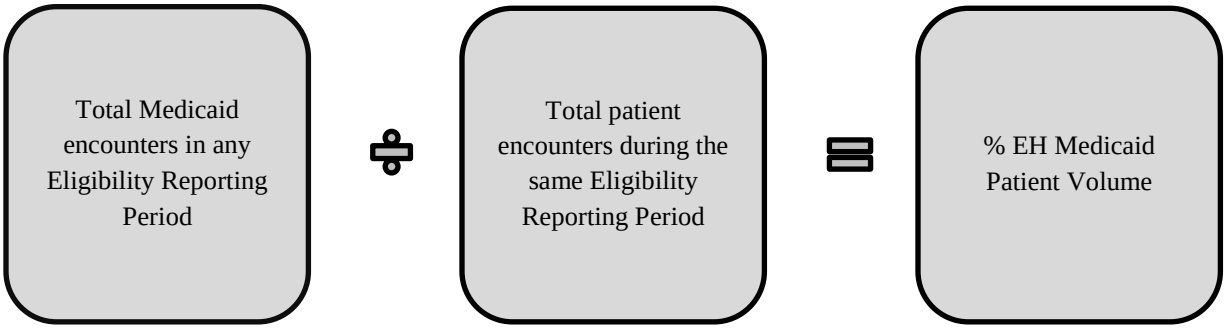
In order for emergency room encounters to count towards the patient volume the emergency department must be part of the hospital.

Exception- A children's hospital is not required to meet Medicaid patient volume requirements.

To calculate Hawaii Medicaid patient volume, an EH must divide:

1. The total Hawaii Medicaid encounters in any 90-day representative, continuous period in the preceding fiscal year; by
2. The total encounters in the same 90-day or period.

a. Total number of inpatient discharges for the selected 90-day period; the encounters also include discharges within the 90 days in which the patient was admitted prior to the start of the selected 90-day period plus could include the total number of emergency department visits in the same 90-day period.



7 Electronic Health Record Functions

Adopt, Implement or Upgrade (AIU)

Adopt, Implement or Upgrade (AIU). Federal regulations allow EPs and EHs who participate in the Hawaii Medicaid EHR Incentive Program to receive incentive payments if they adopt, implement or upgrade to a certified EHR technology in the first year of participation. (This option is not available through the Medicare Incentive Program in which all providers must meet meaningful use in the first year.) At the time of attestation, the EP or EH will be required to provide documentation supporting the claim of AIU, such as a signed contract or paid invoice.

What Does Adopt, Implement or Upgrade Mean?	
Adopt	Acquire, purchase, or secure access to certified EHR technology
Implement	Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements
Upgrade	Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria.

Meaningful Use (MU)

Meaningful Use (MU) of EHR technology is a major goal of this program. CMS has determined that MU will be rolled out in three stages. Stage 1 focuses heavily on establishing the functionalities in certified EHR technology that will allow for continuous quality improvement and ease of information exchange. They include:

- Electronically capturing health information in a structured format;
- Using that information to track key clinical conditions and communicating that information for care coordination purposes (whether that information is structured or unstructured, but in structured format whenever feasible);
- Implementing clinical decision support tools to facilitate disease and medication management;
- Using EHRs to engage patients and families; and
- Reporting clinical quality measures and public health information.

Though some functionalities are optional, all of the functionalities are considered crucial to maximize the value to the health care system provided by certified EHR technology. CMS encourages all EPs and EHs to be proactive in implementing all of the functionalities of Modified Stage 2 in order to prepare for later stages of meaningful use, particularly functionalities that improve patient care, the efficiency of the health care system and public health.

Current federal regulations indicate that providers practicing in multiple locations must provide meaningful use data only for locations that are equipped with certified EHR technology. Fifty percent of the provider's patient encounters must have occurred at those locations equipped with CEHRT. The location is considered "equipped" if

the provider has access to the EHR at the start of the EHR reporting period; whether location-based, remotely-based but accessed through a device at the location, or through the provider's CEHRT-enabled portable device. Locations that do not have access to all the functionalities of ambulatory CEHRT cannot be considered equipped with CEHRT.

Medicare required dually-eligible providers to implement and meaningfully using Certified EHR Technology by program year 2013 to avoid a Medicare reimbursement rate reduction that began on January 1, 2015. Providers must demonstrate meaningful use every year to avoid payment adjustments in subsequent years. The payment reduction starts at 1% and increases each year that a Medicare EP does not demonstrate meaningful use, to a maximum of 5 %. The Hawaii Medicaid EHR Incentive Program does not reduce reimbursements rates for Medicaid payments; however, EPs participating in the Hawaii Medicaid EHR Incentive Program are subject to payment reductions for their Medicare payments if MU was not met in program year 2013.

For Program Year 2015, CMS is allowing EPs the option to submit an Alternate Attestation under the Medicare program to avoid payment adjustments in 2016 and 2017. EPs that utilize the Alternate Attestation have to successfully attest to MU on the CMS Registration and Attestation System by March 11, 2016. EPs that are able to meet patient volume requirements can avoid the Medicare payment adjustment by successfully demonstrating MU to the Hawaii Medicaid EHR Incentive Program, even if submitted after the Medicare attestation period.

Submitting an Alternate Attestation does not switch the EP from the Medicaid Incentive Program to the Medicare Incentive Program, as 2014 was the last year a provider could switch programs. EPs do not need to re-register in CMS's Registration and Attestation System under the Medicare EHR Incentive Program in order to submit an Alternate Attestation. Submission of an Alternate Attestation will not yield a Medicare EHR Incentive payment for the provider and will not count against the EP's remaining participation years in the Hawaii Medicaid EHR Incentive Program. The Alternate Attestation for MU cannot be used in conjunction with a Hawaii Medicaid EHR Incentive Program attestation for AIU in the same year.

Participation Year 1

Per federal rule EPs must begin the program no later than CY 2016 and will receive their last incentive payments in CY 2021, regardless of their fulfillment of all six years of the program. EPs who adopt, implement, or upgrade in their first year of participation do not have to report meaningful use during the first payment year. In the second year of participation, EPs must comply with meaningful use requirements for a continuous 90 day reporting period. Providers must report a full year of meaningful use for all other subsequent payment years, with the exception of program years 2014 and 2015.

EPs who attest to meaningful use of EHR technology in the first year of participation must report 90 days of meaningful use. With the exception of program years 2014 and 2015, providers must report a full calendar year for all other subsequent years.

Example EP Timeline with AIU in First Year				
	2013 First Year EP Receives Payment	2014 First Year EP Receives Payment	2015 First Year EP Receives Payment	2016 First Year EP Receives Payment
CY 2013	AIU			
	No MU reporting period required			
CY 2014	Stage 1 MU	AIU		
	Demonstrate MU for a continuous 90-day period	No MU reporting period required		
CY 2015	Modified Stage 2 MU*	Modified Stage 2 MU*	AIU	
	Demonstrate MU for a continuous 90-day period within the calendar year	Demonstrate MU for a continuous 90-day period within the calendar year	No MU reporting period required	
CY 2016	Modified Stage 2 MU*	Modified Stage 2 MU*	Modified Stage 2 MU*	AIU
	Demonstrate MU for a 1 calendar year period	Demonstrate MU for a 1 calendar year period	Demonstrate MU for a continuous 90-day period within the calendar year	No MU reporting period required
CY 2017	Modified Stage 2 MU* or Stage 3 MU	Modified Stage 2 MU* or Stage 3 MU	Modified Stage 2 MU* or Stage 3 MU	Modified Stage 2 MU* or Stage 3 MU
	Demonstrate MU for a 1 calendar year period. or Providers who choose to implement Stage 3 may demonstrate MU for a continuous 90-day period	Demonstrate MU for a 1 calendar year period. or Providers who choose to implement Stage 3 may demonstrate MU for a continuous 90-day period	Demonstrate MU for a 1 calendar year period. or Providers who choose to implement Stage 3 may demonstrate MU for a continuous 90-day period	Demonstrate MU for a continuous 90-day period within the calendar year
CY 2018	Stage 3 MU	Stage 3 MU	Stage 3 MU	Stage 3 MU
	Demonstrate MU for a 1 calendar year period	Demonstrate MU for a 1 calendar year period	Demonstrate MU for a 1 calendar year period	Demonstrate MU for a 1 calendar year period
CY 2019		Stage 3 MU	Stage 3 MU	Stage 3 MU
		Demonstrate MU for a 1 calendar year period	Demonstrate MU for a 1 calendar year period	Demonstrate MU for a 1 calendar year period
CY 2020			Stage 3 MU	Stage 3 MU
			Demonstrate MU for a 1 calendar year period	Demonstrate MU for a 1 calendar year period
CY 2021				Stage 3 MU
				Demonstrate MU for a 1 calendar year period

*CMS has transitioned Stage 1 MU and Stage 2 MU to "Modified Stage 2 MU" for the 2015-2017 program years. EPs that were scheduled to report for Stage 1 MU in program year 2015 will now report on all the Stage 2 MU objectives, which include alternate exclusions and specifications for measures that were not in Stage 1 MU.

Example EP Timeline with MU in First Year				
	2013 First Year EP Receives Payment	2014 First Year EP Receives Payment	2015 First Year EP Receives Payment	2016 First Year EP Receives Payment
CY 2013	Stage 1 MU			
	Demonstrate MU for a continuous 90-day period			
CY 2014	Stage 1 MU	Stage 1 MU		
	Demonstrate MU for a continuous 90-day period	Demonstrate MU for a continuous 90-day period		
CY 2015	Modified Stage 2 MU*	Modified Stage 2 MU*	Modified Stage 2 MU*	
	Demonstrate MU for a continuous 90-day period within the calendar year	Demonstrate MU for a continuous 90-day period within the calendar year	Demonstrate MU for a continuous 90-day period within the calendar year	
CY 2016	Modified Stage 2 MU*	Modified Stage 2 MU*	Modified Stage 2 MU*	Modified Stage 2 MU*
	Demonstrate MU for a 1 calendar year period	Demonstrate MU for a 1 calendar year period	Demonstrate MU for a 1 calendar year period	Demonstrate MU for a continuous 90-day period within the calendar year
CY 2017	Stage 3 MU	Modified Stage 2 MU* or Stage 3 MU	Modified Stage 2 MU* or Stage 3 MU	Modified Stage 2 MU* or Stage 3 MU
	Demonstrate MU for a 1 calendar year period	Demonstrate MU for a 1 calendar year period. or Providers who choose to implement Stage 3 may demonstrate MU for a continuous 90-day period	Demonstrate MU for a 1 calendar year period. or Providers who choose to implement Stage 3 may demonstrate MU for a continuous 90-day period	Demonstrate MU for a 1 calendar year period. or Providers who choose to implement Stage 3 may demonstrate MU for a continuous 90-day period
CY 2018	Stage 3 MU	Stage 3 MU	Stage 3 MU	Stage 3 MU
	Demonstrate MU for a 1 calendar year period	Demonstrate MU for a 1 calendar year period	Demonstrate MU for a 1 calendar year period	Demonstrate MU for a 1 calendar year period
CY 2019		Stage 3 MU	Stage 3 MU	Stage 3 MU
		Demonstrate MU for a 1 calendar year period	Demonstrate MU for a 1 calendar year period	Demonstrate MU for a 1 calendar year period
CY 2020			Stage 3 MU	Stage 3 MU
			Demonstrate MU for a 1 calendar year period	Demonstrate MU for a 1 calendar year period
CY 2021				Stage 3 MU
				Demonstrate MU for a 1 calendar year period

*CMS has transitioned Stage 1 MU and Stage 2 MU to "Modified Stage 2 MU" for the 2015-2017 program years. EPs that were scheduled to report for Stage 1 MU in program year 2015 will now report on all the Stage 2 MU objectives, which include alternate exclusions and specifications for measures that were not in Stage 1 MU.

Meaningful Use Criteria

If an EH received an incentive payment for AIU in the first year of participation in the Hawaii Medicaid EHR Incentive Program, they will need to successfully demonstrate meaningful use of certified EHR technology in the second year of participation for a continuous 90-day reporting period in the calendar year. The reporting period for all subsequent years will be the entire calendar year.

Most hospitals are eligible for both Medicare and Medicaid EHR incentive payments. Dually-eligible hospitals will be deemed meeting MU for Medicaid if they have met the meaningful use definition through Medicare. EHs should attest to Medicare first, and then attest to Medicaid when they receive confirmation that their Medicare attestation has been approved. Once a dually-eligible hospital has attested under the Medicare program, they are on the Medicare timeline for attestations. An EH that attests to AIU for Medicaid for PY2013 and then attests under Medicare for PY2013 will be required to report a full year of MU for PY2014 in both programs.

EPs do not need to successfully demonstrate meaningful use in their first year of participation in order to receive an incentive payment. The reporting period in the second calendar year of participation is a continuous90 days during the calendar year. The reporting period for all remaining calendar years will be the entire calendar year. Note, CMS will allow a 90-day EHR reporting period for providers who choose to implement Stage 3 in 2017.

Requirements for 2015-2017 EHR Reporting Periods

All providers are required to attest to objectives and measures using EHR technology certified to the 2014 Edition in program year 2015. In program years 2016 and 2017, providers may attest to objectives and measures using EHR technology certified to the 2014 Edition or the 2015 Edition.

For 2015, the EHR reporting period is a continuous 90-day period within the calendar year. Hospitals are allotted a 15 month reporting period for Program Year 2015 (October 1, 2014 to December 31, 2015), but will align with eligible professionals to the regular calendar year from 2016 and beyond. New participants and providers attesting to Meaningful Use for the first time have an EHR reporting period of any continuous 90-day period within the calendar year. The EHR reporting period will be one full calendar year for all returning providers in program year 2017, except for providers who choose to attest to Stage 3 and new participants. These providers will be allowed a 90-day reporting period.

2015-2017 Modified Stage 2 Eligible Professionals

Stage 1 and Stage 2 objectives and measures have been restructured in 2015 to align with Stage 3 and are referred to as “Modified Stage 2”. The program has been streamlined to remove duplicative and redundant measures. All providers are required to attest to a single set of objectives and measures in program year 2015. CMS is aware that this change may have occurred after some providers already started working towards meeting meaningful use in 2015. Providers who were previously scheduled to attest to Stage 1 MU are provided with alternate exclusions and specifications within individual objectives.

A particular objective may be excluded if the following criteria are met:

- Meets the criteria in the applicable objective that would permit the attestation; and
- Attests that the objective is not applicable.
- Exclusions may apply to certain measures; these exclusions are identified within each measure. An exclusion reduces the number of objectives that otherwise apply.

Providers Previously Scheduled to Attest to Stage 1

CMS has created several alternate exclusions and specifications for certain measures. Their intention was to help providers that may not be able to meet the criteria in 2015 and 2016 (for some limited cases); because they require implementation of CEHRT that are beyond the functionality that were required for Stage 1. Providers may opt to use

the alternate exclusions and specifications, but are not required to use them. The SLR will automatically identify providers who are eligible for alternate exclusions and specifications.

These alternate exclusions include:

- Meets the criteria in the applicable objective that would permit the attestation; and excluding Modified Stage 2 measures in 2015 where there is no Stage 1 equivalent. For program year 2016, providers previously scheduled for Stage 1 may claim an alternate exclusion for the CPOE laboratory order (measure 2) and radiology order (measure 3) measures.
- Excluding Modified Stage 2 measures in 2015 when a previous menu measure is now a requirement.
- Using a lower threshold for certain measures in 2015.

2015-2017 Eligible Professional Objectives

To meet Modified Stage 2 MU criteria for 2015-2017, EPs must successfully demonstrate MU for ten objectives, including one consolidated public health reporting objective.

- Protect Patient Health Information
- Clinical Decision Support
- Computerized Provider Order Entry (CPOE)
- Electronic Prescribing
- Health Information Exchange
- Patient Specific Education
- Medication Reconciliation
- Patient Electronic Access
- Secure Electronic Messaging
- Public Health Reporting

For more information on the 2015-2017 EP Objectives and Measures, visit the CMS website at: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EP_ObjectiveMeasuresTable-.pdf

2015-2017 Eligible Professional Clinical Quality Measures

All EPs are required to report on the 2014 CQMs finalized in the Stage 2 rule. EPs must report on 9 of the 64 approved CQMs.

- Recommended core CQMs are encouraged but not required.
    - 9 CQMs for the adult population
    - 9 CQMs for the pediatric population
- Selected CQMs must cover at least 3 of the National Quality Strategy domains
- NQF 0018 is strongly encouraged since controlling blood pressure is a high priority goal in many national health initiatives

In addition, EPs must select CQMs from at least 3 of the 6 key health care policy domains recommended by the Department of Health and Human Services' National Quality Strategy:

- Patient and Family Engagement

- Patient Safety
- Care Coordination
- Population and Public Health
- Efficient Use of Healthcare Resources
- Clinical Process/Effectiveness

2014 Clinical Quality Measures may be found on the CMS website at:
https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2014_ClinicalQualityMeasures.html

2015-2017 Modified Stage 2-Eligible Hospitals

2015-2017 Eligible Hospital Objectives

There are a total of 9 objectives, including one consolidated public health reporting objective with measure options for Modified Stage 2 MU criteria for 2015-2017.

- Protect Patient Health Information
- Clinical Decision Support
- Computerized Provider Order Entry
- Electronic Prescribing
- Health Information Exchange
- Patient Specific Education
- Medication Reconciliation
- Patient Electronic Access
- Public Health Reporting

For more information on the 2015-2017 EH Objectives and Measures, visit the CMS website at:
https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EH_CAH_ObjectiveMeasuresTable2015.pdf

2015-2017 Eligible Hospital Clinical Quality Measures

All EHs and CAHs are required to report on the 2014 CQMs finalized in the Stage 2 rule. Eligible Hospitals and CAHs must report on 16 of the 29 approved CQMs.

In addition, EHs and CAHs must select CQMs from at least 3 of the 6 key health care policy domains recommended by the Department of Health and Human Services' National Quality Strategy:

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population and Public Health
- Efficient Use of Healthcare Resources
- Clinical Process/Effectiveness

2014 Clinical Quality Measures may be found on the CMS website at:
https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/2014_clinicalqualitymeasures.html

Stage 3 Meaningful Use Criteria

The goals for the Stage 3 MU criteria are to focus on promoting improvements in quality, safety and efficiency leading to improved health outcomes, focusing on decision support for national high priority conditions, patient access to self-management tools, and access to comprehensive patient data through robust, patient-centered health information exchange and improving population health. CMS has indicated that more information about Stage 3 MU will be released at a later date.

8 Attestation Process

In order for providers to meet the qualifications for the Hawaii Medicaid EHR Incentive Program, providers are required to attest that the information submitted in their attestation is true and accurate.

Program Attestation Preparation

1. EPs and EHs must ensure their provider information is up to date with MQD. To update provider information, EPs and EHs should complete the DHS Form 1139 Medicaid Application / Change Request Form (pages 1-4) and return it along with their W-9 and any supporting documentation to the Hawaii Medicaid Fiscal Agent. The form is available for download at: http://med-quest.us/PDFs/Frequently%20Used%20Forms%20for%20Providers/DHS%201139.pdf.
2. Register at the Centers for Medicare and Medicaid Registration and Attestation System at https://ehrincentives.cms.gov/hitech/login.action.
3. Create an SLR account at http://hi.arraincentive.com/.
4. Provide a fully executed document demonstrating binding legal or financial commitment to EHR (contract, invoice, receipt, service agreement).
5. Verify your EHR is certified and is on the list from ONC at http://onc-chpl.force.com/ehrcert.
6. EPs must locate your active medical license number and Medicaid ID.
7. EHs must locate the four (4) most recent years of Medicaid cost report data.
8. Determine your Medicaid patient volume you will be reporting for the selected 90 days or greater period.
9. Determine which method of certified EHR technology you will be attesting to - adopt, implement, upgrade or meaningful use.
10. Providers must attest they have read and understand the rules set forth in this provider manual.
11. Complete the Eligibility workbook.
12. Complete the application in the SLR and sign and complete the attestation.

Medicare and Medicaid Registration and Attestation System

Both EPs and EHs are required to begin by registering at the national level with the Centers for Medicare and Medicaid EHR Incentive Program Registration and Attestation System.

EPs registering in the Hawaii Medicaid EHR Incentive Program must enter their National Plan and Provider Enumeration System (NPPES) web user account user ID and password to log into the registration system. EPs may choose to receive the incentive payment themselves or assign them to a clinic or group to which they belong. The EP must select where their payment will go in the payee TIN type. Providers will have to enter the group name, group payee TIN, and the group NPI in order for the provider to issue the payment to the group in which they are associated. In order for the group or clinic to receive the incentive payments from Hawaii, the EP must have a billing provider contract to which the payment is being assigned.

EPs must select between the Medicare and Medicaid incentive programs (prior to 2015 a provider may switch programs once after receiving an incentive payment). If Medicaid is selected, the provider must choose only one state (EPs may switch states annually). Providers must revisit the CMS Registration and Attestation System to make any changes to their information and/or choices, such as changing the program from which they want to receive their incentive payment.

Hospital representative must enter their Identification and authentication User ID and Password to log into the Centers for Medicare and Medicaid EHR Incentive Program Registration and Attestation System. Hospitals must provide their CCN and the NPI for the hospital. The hospital must select the Medicaid state and the hospital type in which they will participate.

EHs seeking payment from both Medicare and Medicaid will be required to visit the Medicare and Medicaid EHR Incentive Program Registration and Attestation System annually to attest to meaningful use before returning to the Hawaii SLR website to complete the attestation for Hawaii's Medicaid EHR Incentive Program. Hawaii Medicaid will assume meaningful use is met for hospitals deemed so for payment from the Medicare EHR Incentive Program.

The Medicare and Medicaid EHR Incentive Program Registration and Attestation System will electronically notify the Hawaii SLR of a provider's choice to enroll in the Hawaii Medicaid EHR Incentive Program. The information completed by the provider at the national website is sent to the Hawaii SLR electronically within 24-48 hours.

9 What is the Payment Methodology?

Payment Methodology for Eligible Professionals

The maximum incentive payment an EP can receive from Hawaii Medicaid equals $63,750, over a period of 6 years, or $42,500 for pediatricians with a 20-29 percent Medicaid patient volume.

Provider	EP	EP-Pediatrician
Patient Volume	30 %	20-29%
Year 1	$21,250	$14,167
Year 2	$8,500	$5,667
Year 3	$8,500	$5,667
Year 4	$8,500	$5,667
Year 5	$8,500	$5,666
Year 6	$8,500	$5,666
Total Incentive Payments	$63,750	$42,500

Pediatricians may qualify to receive the full incentive if the pediatrician can demonstrate that they meet the minimum 30 percent Medicaid patient volume requirements.

Payments for Medicaid Eligible Professionals

An EP must successfully attest to their Year 1 and begin receiving incentive payments no later than CY 2016. EPs are required to designate the incentive payments to a tax ID (TIN) in the Centers for Medicare & Medicaid EHR Incentive Program Registration and Attestation System. The TIN must be associated with either the EP him/herself or a group or clinic with which the EP has a contractual relationship.

For each year a provider wishes to receive a Medicaid incentive payment, determination must be made that he/she was a meaningful user of EHR technology during that year, except in year one in which the provider may be eligible to receive an incentive payment for adopting, implementing or upgrading to a certified EHR technology. Medicaid EPs are not required to participate on a consecutive annual basis, however, the last year an EP may begin receiving payments is 2016, and the last year the EP can receive payments, in totality, is 2021.

Medicare required dually-eligible providers to implement and meaningfully use Certified EHR Technology by program year 2013 to avoid a Medicare reimbursement rate reduction beginning January 1, 2015. The payment reduction starts at 1% and increases each year that a Medicare EP does not demonstrate meaningful use, to a maximum of 5 %. The Hawaii Medicaid EHR Incentive Program does not reduce reimbursements rates for Medicaid payments however EPs participating in the Hawaii Medicaid EHR Incentive Program are subject to payment reductions for their Medicare payments if MU was not met in program year 2013.

Payment Amount for Year:	First Year Medicaid EP Qualifies to Receive Payment 2013	First year Medicaid EP Qualifies to Receive Payment 2014	First year Medicaid EP Qualifies to Receive Payment 2015	First year Medicaid EP Qualifies to Receive Payment 2016
2013	$21,250	-	-	-
2014	$8,500	$21,250	-	-
2015	$8,500	$8,500	$21,250	-
2016	$8,500	$8,500	$8,500	$21,250
2017	$8,500	$8,500	$8,500	$8,500
2018	$8,500	$8,500	$8,500	$8,500
2019	-	$8,500	$8,500	$8,500
2020	-	-	$8,500	$8,500
2021	-	-	-	$8,500
TOTAL Possible Incentive Payments	**$63,750**	**$63,750**	**$63,750**	**$63,750**

Maximum Incentive Payments for EPs

In the event that MQD determines monies have been paid inappropriately, incentive funds will be recouped and refunded to CMS. The initial notification of improper payment will include instructions for the provider to submit payment to repay the improperly paid funds. If the payment is not received within the designated time period, the MMIS payment system will be requested to withhold future Medicaid payments to the provider to offset any funds owed by the provider in question.

Payment Methodology for Eligible Hospitals

Statutory parameters placed on Hawaii Medicaid EHR Incentive payments to hospitals are largely based on the methodology applied to Medicare incentive payments. The specifications described in this section are regulations to which all States must adhere when developing aggregate EHR hospital incentive amounts for Medicaid-EHs. States will calculate hospitals' aggregate EHR hospital incentive amounts on the federal fiscal year (FFY) to align with hospitals participating in the Medicare EHR incentive program.

Hawaii may pay children's hospitals and acute care hospitals up to 100 percent of an aggregate EHR hospital incentive amount made in 3 payments. Section 1905(t)(5)(D) requires that no payments can be made to hospitals after 2016 unless the provider has been paid a payment in the previous year. Prior to 2016, Medicaid incentive payments to hospitals can be made on a nonconsecutive, annual basis. The aggregate EHR hospital incentive amount is calculated using an overall EHR amount multiplied by the Medicaid share.

If a hospital continues to be eligible for participation in the Hawaii Medicaid EHR Incentive Program each payment year, MQD will pay, as follows, the aggregate amount to that hospital:

(1) in the first year of participation, 50 percent of the aggregate amount;

(2) in the second year of participation, 40 percent of the aggregate amount; and

(3) in the third year of participation, 10 percent of the aggregate amount.

Hawaii is responsible for using auditable data sources to calculate Medicaid aggregate EHR hospital incentive amounts, as well as determining Hawaii Medicaid EH incentive payments to those providers. Auditable data sources include:

- Providers' Medicare cost reports;
- State-specific Medicaid cost reports;
- Payment and utilization information from the Hawaii Prepaid Medical Management Information System (HPMMIS), or other automated claims processing systems or information retrieval systems; and
- Hospital financial statements and hospital accounting records.

For purposes of the Hawaii Medicaid EHR hospital incentive payment program, the overall EHR amount is equal to the sum over 4 years of (1)(a) the base amount (defined by statute as $2,000,000); plus (b) the discharge related amount defined as $200 for the 1,150th through the 23,000th discharge for the first year (for subsequent years, CMS assumes discharges increase by the provider's average annual rate of growth for the most recent four (4) years for which data are available per year): multiplied by (2) the transition factor for each year equals 1 in year 1, ¾ in year 2, ½ in year 3, and ¼ in year 4.

The statute specifies that the payment year is determined based on a Federal fiscal year. Section 1886(n)(2)(C) of the Act provides the Secretary with authority to determine the discharge related amount on the basis of discharge data from a relevant hospital cost reporting period, for use in determining the incentive payment during a Federal fiscal year.

Federal fiscal years begin on October 1 of each calendar year, and end on September 30 of the subsequent calendar year. Hospital cost reporting periods can begin with any month of a calendar year, and end on the last day of the 12th subsequent month in the next calendar year. For purposes of administrative simplicity and timeliness, Hawaii will use data on the hospital discharges from the hospital fiscal year that ends during the Federal fiscal year prior to the fiscal year that serves as the first payment year.

The discharge-related amount is $200 per discharge for discharges 1,150 through 23,000. To determine the discharge-related amount for the three subsequent years that are included in determining the overall EHR amount, Hawaii will assume discharges for an individual hospital have increased by the average annual growth rate for an individual hospital over the most recent four (4) years of available data from an auditable data source. Per federal regulations, if a hospital's average annual rate of growth is negative over the 3 year period, it will be applied as such.

The overall hospital EHR amount requires that a transition factor be applied to each year. This transition factor equals 1 for year 1, ¾ for year 2, ½ for year 3, and ¼ for year 4, as provided for in sections 1886(n)(2)(A) and 1886(n)(2)(E) of the Act, and as incorporated through section 1902(t)(5)(B) of the Act.

The "Medicaid Share", against which the overall EHR amount is multiplied, is essentially the percentage of a hospital's inpatient, non-charity care days that are attributable to Medicaid inpatients. More specifically, the Medicaid share is a fraction expressed:

Estimated Medicaid inpatient-bed-days plus estimated Medicaid managed care inpatient-bed-days;
Divided by;
Estimated total inpatient-bed-days multiplied by ((estimated total charges minus charity care charges) divided by estimated total charges).

As indicated in the above formula, the Medicaid share includes both Medicaid inpatient-bed-days and Medicaid managed care inpatient-bed-days. Nursery and swing bed days should be excluded.

In addition, because the formula for calculating the Medicaid share requires a determination of charity care charges, Hawaii will use the Medicare 2552-96 or the revised Medicare 2552–10, Worksheet S–10 or another auditable data source to determine the charity care portion of the formula. In the absence of sufficient charity care data to complete the calculation, section 1886(n)(2)(D) of the Act, requires the use of uncompensated care data to derive an appropriate estimate of charity care, including a downward adjustment for bad debts. CMS interpreted bad debt to be consistent with the Medicare definition of bad debt as promulgated at § 413.89(b)(1).

Finally, per section 1886(n)(2)(D) of the Act, to the extent there is simply not sufficient data that would allow us to estimate the inpatient bed-days attributable to Medicaid managed care patients. The statute directs that such figure is deemed to equal 0. Likewise, if there is simply no sufficient data for the State to estimate the percentage of inpatient bed days that are not charity care (that is, [estimated total charges - charity care charges]/estimated total charges), the statute directs that such figure is deemed to equal 1. Unlike Medicaid EPs, who must waive rights to duplicative Medicare incentive payments, hospitals may receive incentive payments from both Medicare and Medicaid, contingent on successful demonstration of meaningful use and other requirements under both programs.

The last year that a hospital may begin their Year 1 attestation to receive Medicaid incentive payments is FY 2016. States must make payments over a minimum of 3 years. Additionally, in any given payment year, no annual Medicaid incentive payment to a hospital may exceed 50 percent of the hospital's aggregate incentive payment. Likewise, over a 2- year period, no Medicaid payment to a hospital may exceed 90 percent of the aggregate incentive.

Eligible Hospital Incentive Payment Calculation Methodology

Calculating the overall incentive payment is a multi-step process and utilizes hospital data on total discharges (excluding nursery discharges) to compute a growth rate which is used to determine projected eligible discharges. A base amount of $2,000,000 is added to the eligible discharge amount and a transition factor is applied to arrive at the overall EHR amount. The overall EHR amount needs to be adjusted for charity care before Medicaid's share can be calculated. The aggregate EHR hospital incentive payment is calculated as the product of the [overall EHR amount] times [the Medicaid Share].

Calculating the overall EHR amount is a multistep process. Hospitals are required to provide and attest to the following information for the incentive payment to be calculated:

- Total Inpatient Discharges for the most recent four (4) fiscal years
- Total Number of Medicaid Inpatient Bed Days (excluding nursery and swing)
- Total Number of Inpatient Bed Days
- Total Hospital Charges
- Total Charges for Charity Care

This is an example of the steps that will be followed to calculate incentive payments to EHs. The numbers do not represent the actual hospital discharges and incentive payments of the State of Hawaii, and are used solely for the purpose of demonstrating how Eligible Hospital EHR incentive payments are calculated.

How the Annual Discharge Data is Used

Step 1: Calculating the Average Annual Growth Rate:

To calculate the average annual growth rate, the hospital reports the total discharges for the four (4) most recent hospital fiscal year cost reports. Total discharges are the sum of all inpatient discharges (excluding nursery discharges).

Federal Fiscal (FF) Year	Total Discharges[1]		Previous Year		Difference		Previous Year		Percent Change		Years of Data		Average Growth Rate
Base Federal Fiscal Year	17,500	-	17,000	=	500	÷	17,000	=	0.029				
1st Previous FF Year	17,000	-	16,500	=	500	÷	16,500	=	0.030				
2nd Previous FF Year	16,500	-	16,000	=	500	÷	16,000	=	0.031				
3rd Previous FF Year	16,000								0.090	÷	3	=	**3.03%**

[1] Source of Total Discharges: Medicare Cost Report Worksheet S-3, Part I, col. 15, line 14

Step 2: Applying the Average Annual Growth Rate to the Base Number of Discharges

The number of discharges for the base year and subsequent years is added to the average annual growth rate (3.03%) to project the number of discharges over the next 3 years.

Year	Total Discharges		Average Growth Rate		Total Discharges (Original)		Adjusted Discharges
Year 1 (Base Year)	17,500	×	0	+	17,500	=	17,500.00
Year 2	17,500	×	3.03%	+	17,500	=	18,030.25
Year 3	18,031	×	3.03%	+	18,031	=	18,577.34
Year 4	18,577	×	3.03%	+	18,577	=	19,139.88

Step 3: Determine the Number of Eligible Discharges and Multiply by the Discharge Payment Amount

For each discharge between 1,150 and 23,000, the discharge rate is added to the base amount.

1. For the first through the 1,149th discharge, $0
2. For the 1,150th through the 23,000th discharge, $200 per discharge
3. For any discharge greater than the 23,000th, $0

Year	Adjusted Discharges				Allowed Discharges (max=21,851)		Discharges Rate		Eligible Discharge Cost
Year 1 (Base Year)	17,500.00	-	1,150	=	16,350.00	×	$200	=	$3,270,000.00
Year 2	18,030.25	-	1,150	=	16,880.25	×	$200	=	$3,376,050.00
Year 3	18,577.34	-	1,150	=	17,427.34	×	$200	=	$3,485,468.00
Year 4	19,139.88	-	1,150	=	17,989.88	×	$200	=	$3,597,976.00

Step 4: Add the Eligible Discharge Cost to the Base Year Amount of $2,000,000 per payment year

Step 5: Multiply the Medicaid Transition Factor by the Total Eligible Discharge Payment to arrive at the Overall EHR Amount

The transition factor equals 1 for year 1, ¾ for year 2, ½ for year 3 and ¼ for year 4. All four years are then added together to account for the yearly and overall initial EHR payment.

Step 4						Step 5			
Year	**Eligible Discharge Cost**		**Base Year Amount**		**Total Eligible Discharge Payments**		**Transition Factor**		**Overall EHR Amount**
Year 1 (Base Year)	$3,270,000.00	+	$2,000,000	=	$5,270,000	×	1	=	$5,270,000.00
Year 2	$3,376,050.00	+	$2,000,000	=	$5,376,050.00	×	.75	=	$4,032,037.50
Year 3	$3,485,468.00	+	$2,000,000	=	$5,485,468.00	×	.50	=	$2,742,734.00
Year 4	$3,597,976.00	+	$2,000,000	=	$5,597,976.00	×	.25	=	$1,399,494.00
						Overall EHR Amount			**$13,444,265.50**

How the Total Number of Medicaid Inpatient Bed Days, Total Inpatient Days, Total Hospital Charges and Total Charity Care Charges are Used

Step 6: Calculate the Medicaid Share

The next step requires that the Medicaid Share be applied to the overall EHR amount. The Medicaid Share is the percentage of Medicaid inpatient bed-days divided by the estimated total inpatient bed days adjusted for charity care. **Note: All inpatient bed day totals should exclude nursery care.** To calculate the Medicaid Share, the hospital will need to provide the following information from the most recently filed cost report. The most recently filed cost report is defined as the hospital costs report ending prior to the start of the current federal fiscal year.

	Total Charges[1]		Charity Care Charges[2]		Total Charges		% of Non-charity Charges		Total Inpatient Days[3]		Adjusted Inpatient Days		Medicaid Inpatient Days FFS[4]		Medicaid Inpatient Days MC[5]		Adjusted Inpatient Days		Medicaid Share
Base Year	$5,000,000	-	$1,000,000	÷	$5,000,000	=	0.80	×	50,000	=	40,000		1,750	+	1,350	÷	40,000	=	**7.75%**

[1] Source: Medicare Cost Report, Worksheet C, Part I, col. 8, line 200
[2] Source: Medicare Cost Report, Worksheet S-10, col. 3, line 20
[3] Source: Medicare Cost Report, Worksheet S-3, part I, col. 8, line 1, 2 + lines 8-12
[4] Source: Medicare Cost Report, Worksheet S-3, part I, column 7, line 1 + lines 8-12
[5] Source: Medicare Cost Report, Worksheet S-3, part I, col. 7, line 2

The "Medicaid Share", against which the overall EHR amount is multiplied, is essentially the percentage of a hospital's inpatient, non-charity care days that are attributable to Medicaid inpatients. More specifically, the Medicaid share is a fraction expressed:

$$\text{Medicaid Inpatient Bed Days} \div \text{Total Inpatient Days} \times \left(\frac{\text{Total Hospital Charges} - \text{Charity Care Charges}}{\text{Total Hospital Charges}} \right)$$

(Total Hospital Charges - Charity Care Charges) ÷ Total Hospital Charges = Charity Care Adjustment

Step 7: Calculate the Aggregate Incentive Payment Amount

To arrive at the aggregate incentive amount multiply the overall EHR Amount ($13,444,265.50) by the Medicaid Share of 7.75%.

	Overall EHR Amount		Medicaid Share		Aggregate EHR Amount
Base Year	$13,444,265.50	×	7.75%	=	**$1,041,930.58**

Step 8: Distributed Over 3 Incentive Payments

MQD will issue hospital incentive payments in three (3) incentive payment amounts. The following illustrates an example of how the payments will be issued in three (3) payment years at 50, 40 and 10% respectively. The hospital would need to continue to meet the eligibility requirements and meaningful use criteria in all incentive payment years.

Payment Year	Aggregate EHR Amount		Payout Percentage		Annual Incentive Payment Amount
Year 1	$1,041,930.58	×	50%	=	**$520,965.29**
Year 2	$1,041,930.58	×	40%	=	**$416,772.23**
Year 3	$1,041,930.58	×	10%	=	**$104,193.06**

Payments for Medicaid Eligible Hospitals

EH payments will be made in alignment with the federal fiscal year and an EH must begin receiving incentive payments no later than FFY 2016. EHs will assign the incentive payments to a tax ID (TIN) in the Centers for Medicare & Medicaid EHR Incentive Program Registration and Attestation System.

For each year a hospital wishes to receive a Medicaid incentive payment, a determination must be made that the hospital was a meaningful user of EHR technology during that year, except in year one in which the hospital may be eligible to receive an incentive payment for adopting, implementing or upgrading to a certified EHR technology. Hawaii Medicaid will assume meaningful use is met for hospitals deemed so for payment from the Medicare EHR Incentive Program. Furthermore, EHs that have been deemed meaningful users for the Medicare EHR Incentive Program prior to attesting to the Medicaid EHR Incentive Program are not eligible to attest to adopt, implement or upgrade for Year 1 of the Medicaid EHR Incentive Program, in accordance with CMS policy, and will be deemed a meaningful user as a Medicaid EH. Medicaid EHs are not required to participate on a consecutive annual basis, however, the last year a hospital may begin receiving payments is 2016, and the last year the hospital can receive payments is 2021.

Hawaii Medicaid currently requires that all hospitals submit a valid NPI as a condition of Hawaii Medicaid provider enrollment. Each hospital will be enrolled as a Hawaii Medicaid provider and will therefore, meet the requirement to receive an NPI.

In the event that MQD determines monies have been paid inappropriately, incentive funds will be recouped and refunded to CMS. The initial notification of improper payment will include instructions for the provider to submit payment to repay the improperly paid funds. If the payment is not received within the designated time period, the MMIS payment system will be requested to withhold future Medicaid payments to the provider to offset any funds owed by the provider in question.

10 Validation and Approval Process

Requesting Payment

Once the attestation is complete, it will be validated to ensure that the provider meets all of qualifications for the program.

Missing or additional information may be requested to support the provider attestation. A follow-up with the provider will be made after 30 days of the initial request if no response was received. A final follow-up will be made to the provider before the grace period of the attestation program year ends.

Before determining if the provider meets the requirements of the program, MQD will evaluate the facts to which the provider has attested and may request additional information from sources other than the provider to validate the providers attestation submitted.

Upon completion of the attestation process, including submission of the electronic attestation, receipt of required documentation, and review and acceptance by MQD, an incentive payment will be approved. The State of Hawaii will issue the payment to the tax ID identified in the Centers for Medicare & Medicaid EHR Incentive Program Registration and Attestation System. This entire process may take up to 60 business days to complete once the original hard copy attestation is received.

If MQD determines that the provider does not meet the requirements of the program the provider will be notified of the reason for denial. The provider will be notified of their right to request an appeal. If a change occurs in the information that MQD used to deny participation, or that previously resulted in a failure to receive CMS validation, the provider may submit a new or updated attestation at any time during that payment year.

Credit Balances

MQD will follow its regular credit balance recovery process and workflows. In the event that an attesting provider has a credit balance, the EHR incentive payment will be used to offset the credit balance, if the attesting provider is assigning payment to themselves.

Administrative Appeals

A provider may appeal MQD's decision on any of the following:

- Deny participation in the Hawaii Medicaid EHR Incentive Program;
- Suspend an incentive payment;
- Require repayment of all or a portion of incentive payment;
- Terminate participation in the Hawaii Medicaid EHR Incentive Program.

To appeal a decision, a provider must submit the Hawaii Medicaid EHR Incentive Program Appeal Form to the Hawaii Medicaid Fiscal Agent Office no later than sixty (60) days after the date of denial, suspension, repayment, or termination.

The appeal justification must specify the basis upon which MQD's decision is challenged and include supporting documentation specific to the appeal reason which was not previously submitted.

A review of the appeal will be conducted, and the provider will be notified in writing of MQD's decision to approve or deny. If the review results in a denial, the provider will be notified of the reasons for the denial.

If MQD has suspended an incentive payment, MQD may continue suspending the payment until a final determination is made regarding the appropriateness of the suspension.

The completed Hawaii Medicaid EHR Incentive Program Appeal form and supporting documentation should be sent to:

Hawaii Medicaid Fiscal Agent
Attn: Hawaii Medicaid EHR Incentive Program
P.O. Box 1220
Honolulu, HI 96807-1220

A provider who is not satisfied with the appeal decision may request a Fair Hearing by submitting a written request to the Director of the Department of Human Services no later than thirty (30) days after the date of the appeal decision.

The request for Fair Hearing should be sent to:

DHS/Medicaid Administrator
Attn: Hawaii Medicaid EHR Incentive Program
P.O. Box 700190
Kapolei, HI 96704-0190

The request for Fair Hearing must include:

- A copy of the Hawaii Medicaid EHR Incentive Program Appeal Form submitted by the provider;
- A copy of MQD's appeal decision;
- A description of the basis upon which the decision is being appealed; and
- Any additional documentation that supports the basis upon which the provider is making the appeal.

The Director of the Department of Human Services shall appoint a hearings officer following the receipt of a written request for an administrative hearing that is filed within the thirty (30) day time limit, and accompanied by pertinent documents and written evidence relevant to the case.

The Director of the Department of Human Services' review of the original appeal record, the rendered decision, and any additional material submitted by the provider and the MQD constitutes the Fair Hearing. A decision by the Director of the Department of Human Services under this subsection is the final administrative decision of the Department.

Program Integrity

To lessen the risk of fraud and abuse, MQD plans to have a rigorous pre-payment verification process. 100% of attestations will undergo pre-payment verifications; and 100% of approved attestations will undergo a post-payment risk assessment for audit selection. Post-payment audits will be conducted as desk and/or onsite reviews. Be sure to keep supporting documentation for information used in the preparation of AIU or Meaningful Use attestation.

Payment Recoupment

Overpayments discovered by providers must be promptly reported to MQD.

In the event that MQD determines an inappropriate payment has been paid, incentive funds will be recouped and refunded to CMS. The provider will be notified of the request for recoupment, the amount involved, and the action to be taken. The state reserves the right to request a refund to be received within 60 days. If the payment is not received within the designated time period, the payment system will be requested to withhold future Medicaid payments to the provider to offset any funds owed by the provider in question.

Payments in full should be made payable to "Hawaii Medicaid" and sent to:

Hawaii Medicaid Fiscal Agent
EHR Incentive Program
P.O. Box 1480
Honolulu, HI 96807-1480

Please include a copy of the request for recoupment notification from MQD.

11 Eligibility at a Glance

Qualifying Eligible Professionals (EP)		
1	Currently Enrolled with Hawaii Medicaid	
2	Hospital-based EPs are NOT Eligible	• 90% or more of services are performed in a hospital inpatient or emergency room setting.
3	Provider Type	• Certified Nurse-Midwife • Dentist • Doctor of Medicine • Doctor of Osteopathic Medicine • Optometrist • Pediatrician (MD or DO) • Physician Assistants (PA) in an FQHC or RHC so-led by a PA • Registered Nurse Practitioners
4	Patient Volume in a 90 Day Period	• 30% Medicaid • 20-29% Medicaid – Pediatricians = 2/3 of incentive payment • 30% Other Needy Individuals - Medical EPs practicing predominantly in FQHC or RHC

Qualifying Eligible Hospitals (EH)			
1	Currently Enrolled with Hawaii Medicaid		
2	Hospital Types	Acute Care Hospital (includes CAHs and cancer hospitals) Children's Hospital	• Avg. Length of Stay < 25 days • CCN last 4 of o 0001 - 0879; 1300 - 1399 o 3300 - 3399 Not applicable to children's wings of larger hospitals
3	Patient Volume Over a 90 Day Period	Acute Care Hospital Children's Hospital	• 10% Medicaid • No Requirement

12 Definitions for the EHR Incentive Program

Acceptable documentation means satisfactorily completed written evidence of an approved phase of work or contract and acceptance of the evidence thereof by Hawaii Medicaid. Acceptable documentation will refer to the certified EHR technology by name and will include financial and/or contractual commitment. Document date does not have to be within the preceding fiscal year, if the reported version of the EHR technology was certified after the document date. See examples below:

- Copy of contract
- Copy of invoice
- Copy of receipt
- Copy of purchase agreement
- Copy of user license agreement

Acute care hospital means a health care facility— (1) Where the average length of patient stay is 25 days or fewer; and (2) With a CMS certification number (previously known as the Medicare provider number) that has the last four digits in the series 0001–0879 or 1300–1399; or (3) Critical Access Hospitals

Adopt, implement, or upgrade (AIU) means— (1) Acquire, purchase, or secure access to certified EHR technology (proof of purchase or signed contract will be an acceptable indicator); (2) Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements; or (3) Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria.

Children's hospital means a separately certified children's hospital, either freestanding or hospital-within hospital that— (1) Has a CMS certification number, (previously known as the Medicare provider number), that has the last 4 digits in the series 3300–3399; and (2) Predominantly treats individuals less than 21 years of age.

Hospital-Based means a professional furnishes ninety percent (90%) or more of their Hawaii Medicaid-covered professional services during the relevant EHR reporting period in a hospital setting, whether inpatient or emergency room, through the use of the facilities and equipment of the hospital; verified by HPMMIS claims analysis.

Medicaid Encounter for an EP means services rendered to an individual on any one day where:

- Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid for part or all of the service; or
- Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid all or part of the individual's premiums, co-payments, and cost-sharing; or
- The individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under section 1115 of the Act) at the time the billable service was provided.

Medicaid Encounter for an EH means services rendered to an individual per inpatient discharge or services rendered to an individual in an emergency room on any one day where:

- Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid for part or all of the service; or

- Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid all or part of the individual's premiums, copayments, and cost-sharing.
- The individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under section 1115 of the Act) at the time the billable service was provided.

This includes encounters for dual eligible individuals (i.e. individual eligible for both Medicaid and Medicare)

Hawaii Prepaid Medical Management Information System (HPMMIS) means the Medicaid claims processing system.

Needy Individuals mean individuals that meet one of the following:

- Received medical assistance from Medicaid or the Children's Health Insurance Program. (or a Medicaid or CHIP demonstration project approved under section 1115 of the Act);
- Were furnished uncompensated care by the provider;
- Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

Other Needy Individuals are defined as individuals that meet one of the following:

- Were furnished uncompensated care by the provider;
- Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

Patient panel is the alternate volume calculation available only to EPs that are primary care providers (PCP) that are treating Medicaid managed care or medical home patients, as well as any additional encounters outside of a care management arrangement (fee-for-service).

Patient volume means the proportion of an EPs or EHs patient encounters that qualify as a Medicaid encounter. This figure is estimated through a numerator and denominator and is defined as:

- [Total (Medicaid) patient encounters in any 90-day representative, continuous period within the preceding calendar year or within the preceding 12 month period from the date of attestation/Total patient encounters in that same 90-day period] * 100

Pediatrician means a Medical doctor who diagnoses, treats, examines, and prevents diseases and injuries in children. A pediatrician must (1) hold a valid, unrestricted medical license, **and** (2) hold a board certification in Pediatrics through either the American Board of Pediatrics (ABP) or the American Osteopathic Board of Pediatrics (AOBP).

Practices predominantly means an EP practicing at an FQHC or a RHC clinical location, for over 50 percent of their total patient encounters in a six (6) month period in the previous calendar year or the twelve (12) month period preceding the attestation.

Unduplicated Encounters means that an eligible professional may not include the same encounters more than once. There may be multiple encounters with patients (even with patients included on the panel), but these may not be counted in more than one place in the equation. In addition, the "unduplicated encounters" can only be encounters with non-panel Medicaid patients that occurred during the representative 90-day period.

Hawaii Medicaid EHR Incentive Program Appeal Form

Providers may use this form to appeal any of the following decisions made under the Hawaii Medicaid EHR Incentive Program:

- Deny participation in the Hawaii Medicaid EHR Incentive Program.
- Suspend incentive payment.
- Require repayment of all or a portion of an incentive payment.
- Terminate participation in the Hawaii Medicaid EHR Incentive Program.

To appeal a decision, this form must be submitted no later than 60 days after the date of denial, suspension, repayment, or termination. **All fields on this form must be completed.**

The completed form and any supporting documentation should be sent to: ***Hawaii Medicaid Fiscal Agent, ATTN: Hawaii Medicaid EHR Incentive Program, P.O. BOX 1220, Honolulu, HI 96807-1220.***

For questions please visit http://med-quest.us/providers/ElectronicHealthRecordIncentiveProgram.html

Provider Name:	Organization Name (if any):
Medicaid Provider ID:	NPI Number:
Contact Name:	Contact Telephone Number:
Mailing Address:	Provider E-mail:

List of Attached Documents:

Reconsideration Justification (Please give a complete explanation for the appeal reason. Attach copies of any documents that support the appeal):

Provider Signature:	Date:

Version 1.0 20130910

For Office Use Only:

Filed Within 60 Day Time Limit:	☐ *Yes* ☐ *No*
Forwarded to:	☐ *MQD*
Completed By:	
MQD Appeal Review Completion Date:	
Completed By:	
Forwarded to:	☐ *Field Rep*